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Fetation

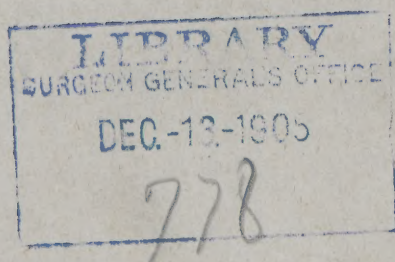
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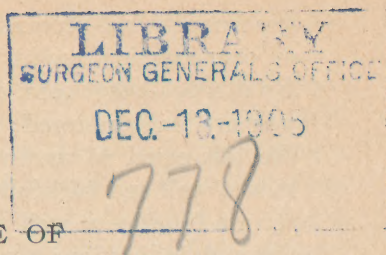
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A UNIQUE CASE OF

## EXTRA-UTERINE FETATION.<sup>1</sup>

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I DESIRE to bring before this international forum a unique specimen which is instructive in reference to the etiology and diagnosis of extra-uterine pregnancy, and is, moreover, thoroughly corroborated by clinical history and by close personal observation of the patient.

The specimen itself is preserved, and the history of the patient, who has been under constant observation for the last four years, is so complete and known to so many that the facts revealed and the deductions drawn therefrom are proven conclusively, with the precision of a chemical experiment, and can be readily verified.

The *clinical history* is, in brief: A. B. was brought on a stretcher into the gynecological department of the St. Louis Polyclinic four years ago. Patient, who had been bed-ridden for six months as a sequence to violent pelvic inflammation, was in a depleted state, exceedingly nervous, suffering from endometritis and perimetritis, with marked salpingitis and ovariitis. Under the treatment inaugurated relief from excessive suffering was soon obtained; yet convalescence was slow; improvement of the complicated pelvic state, as well as her general condition, was barely perceptible from month to month; but by persistent clinical attendance and strict obedience to all directions given for two full years, she was finally enabled to undertake light work for self-support. Even after this she continued under constant observation; although her visits to the clinic became

<sup>1</sup> Read before the First International Congress of Gynecology, in Brussels.



less frequent, she promptly returned for treatment whenever cold or over-exertion might have caused a temporary aggravation. By this persistent care, so unusual in an out-door patient, health was gradually restored; she became robust and strong, so that she felt equal to undertaking the duties of a sick-nurse, and served well and faithfully in this capacity in the hospital, and in private families as well. Pelvic irritation had disappeared, and, although indurations remained and adhesions could be traced, no inflammatory symptoms recurred.

For the last year or two she had been practically a well woman, and such was her condition when she was seized with what she herself termed cramps; abdominal pain due to indigestion, as she stated for the purpose of deceiving the attending physician. These cramping pains were accompanied by occasional spells of weakness and fainting, and, after some days, were followed by a slowly developing peritonitis, not distinctly pelvic in character, so that her description of the pain as gastric seemed all the more natural; and as the fever lessened and patient improved decidedly for several days after entering the hospital, the treatment was supposed to be to the point and was persisted in; but soon a change came and sepsis developed, which rapidly led to a fatal termination.

The case appeared thus by reason of the deception practised by the sufferer, who persistently misrepresented; and having been in constant contact with physicians and with disease for years as nurse or patient, it was easy for her to dissemble and avoid examination. She sought to appear as suffering from constipation and resulting disturbances of digestion, and her story seemed a plausible one. Menstruation had always been somewhat irregular, and cessation or any unusual irregularity was denied, likewise any unusual flow of blood or pelvic pain. All conditions pointing to pelvic disease, to pregnancy or miscarriage, were denied; if hemorrhage had occurred it was successfully concealed and evidently checked at the time of an examination; all suffering was referred to the stomach and bowels.

I must here state that in this last illness patient was not under my care or that of my assistants. I saw her but casually during the days of improvement and apparent convalescence, to encourage her; and again in the septic state, when, after a hasty examination, I left a note for the attendant, an able surgeon, saying: "I believe this woman to be doomed unless you ope-



rate." But, conditions not appearing to him as indicated by me the suggestion was not acted upon.

*The actual facts*, as in part confessed to me in her last days, and in part revealed by the symptoms seen and corroborated by the post-mortem examination, give the case a very different aspect. Patient passed the usual time for the recurrence of her menstrual period without any evidence of a flow, and soon began to suffer from nausea and occasional vomiting, which she referred to gastric disturbances following her irregular mode of life, cold meals, and other sequences of her "light housekeeping." Between two and three weeks after the time when she might have expected her period she was seized with faintness and pelvic discomfort; then came cramping pains and, as it appears, some bloody discharge from the uterus, to what extent I cannot say. Cramping pains, general debility, dimness of vision, lightness of head were such that she sought medical advice and walked to the physician's office, where she fainted, as was then supposed, from the pain caused by a hypodermic injection of morphine, but, as the accompanying dimness of vision would make it appear, by the rupture of the sac and following hemorrhage, or by an increase of the pre-existing internal oozing. She was sent to the hospital, and there developed evidences of peritonitis, but appeared to be improving under treatment, pain as well as pulse and temperature subsiding. It would appear that she was about recovering from the disturbance produced by the rupture and consequent loss of blood, which was not in great quantity, as shown by the post-mortem examination; but within a few days, not quite a week after she first began to complain, her condition rapidly grew worse, amid septic symptoms evidently resulting from her filthy condition, the absence of all antiseptics, and even of cleanliness or washes—as no discharge of any kind had been observed or complained of, and no indication of any possible uterine or pelvic irregularity had been given, such precautions had not been observed. Infection was evidently carried by her own finger to the accumulation of congealed blood in the vagina, as she confessed her repeated digital examinations and manipulations, having probably made efforts to penetrate the uterine cavity in her dread of pregnancy.

It was in this septic state that I saw and examined her, finding some blood in the vagina; the uterus somewhat enlarged, but not more than might have been expected with her history; the



left tube and ovary were indurated, but the right could not be felt through the sensitive and distended abdominal walls; the pelvis was free; there was no unusual resistance to be detected anywhere, either in the cul-de-sac or in the ovarian region, but there was an apparent point of greatest tenderness and slightly increased resistance in the region of the appendix vermiformis, which led me to urge operation upon the attending physician—though, as I afterward found, this was deemed inexpedient, as no such resistance was observed at the time of his examination, and within forty-eight hours she died.

*The post-mortem examination* revealed localized congestion of the peritoneum and shreds of clotted blood throughout the lower portion of the abdomen, especially about the posterior portion of the uterus and the right tube, but no larger clots or accumulations; the curious feature of the case being the location of this tube, with ovisac and ovary, well up in the right side, by reason of existing adhesions and the attachment of the tube to the appendix vermiformis.

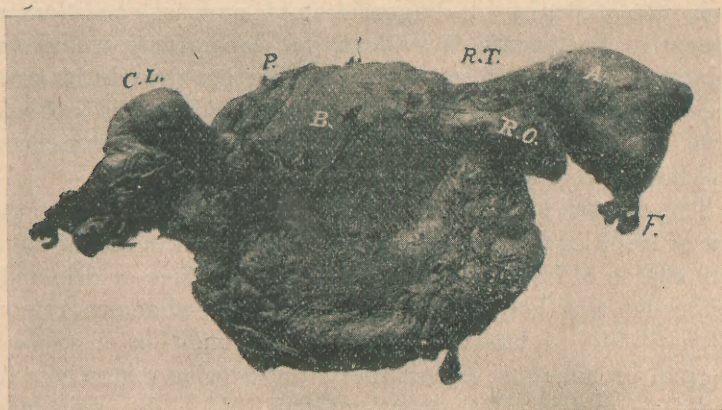
The specimen, as well depicted in the photograph, shows some unusual and well-marked features; shreds of inspissated blood or small tissue-like clots (B) covering the broad ligaments and the fundus and posterior portion of the uterus, which was somewhat enlarged and hard. No traces of any more recent inflammation were visible in the pelvic viscera beyond such as may have followed the rupture—a slight redness of the uterine surface and the congestion of the superimposed intestinal coils. The distorted condition of the pelvic viscera, adhesions, contractions, and indurations, indicated the extent and violence of the first inflammation, four years previous, to which all her pelvic trouble is referable; and an examination of the specimen proves that all pathological changes which were not of quite recent origin, following the rupture, must be referred to the long past perimetritis, the source of all changes and suffering; and we know well, as the clinical history shows, that this is actually so, that no inflammation has occurred since.

A prominent feature is the corpus luteum (C L) in the left ovary (L O), quite recent, unusually perfect, and well shown in the plate; the ovary itself is small, flat, and firmly united with the tube.

The left tube (L T) is thickened, indurated, contorted, and, what is most important in the consideration of this case, *occluded*,



as microscopic examination shows. The right ovary (R O) is small, atrophic, drawn out of its usual position by close connection to the tube and ovisac; it gives no indication whatsoever of a corpus luteum, or even a recently ruptured follicle, and the tissue is indurated. The right tube, which is but little thickened in its undistended uterine half, is dragged well away from its usual site by an attachment to the appendix vermiformis; the peripheral portion is distended by the ovum, forming a sac three centimetres broad by four in length. In the centre of the upper portion of this ovisac is the rupture (R), one centimetre in diameter, now firmly closed by a clot which is seen to protrude. Upon the posterior surface of the distended portion of the



tube, one and a half centimetres from the median end and two and a quarter centimetres from the rupture, is the point of adhesion to the appendix vermiformis (A), the remnants of which are distinctly visible. That the pregnancy is purely tubal is evident from the perfect preservation of the fimbriæ (F).

A survey of this specimen demonstrates with unusual distinctness (1) the circuitous route taken by the ovule; (2) the difficulty of diagnosis by reason of the dislocation of the parts; and (3) the possibility of a cure of serious pelvic troubles without resort to the knife.

1. As the corpus luteum is in the left ovary, the ovule must have come from this source; and, the left tube being occluded, it was forced to travel through the abdominal cavity to the region of the appendix vermiformis and there enter the right



tube, where it was impregnated. Nor is any other supposition possible, since the ostium tubæ could never have approached the ovary of the other side, by reason of the firm adhesion surrounding the tube and its attachment to the appendix; and I should deem it unlikely, to say the least, that the ovule should have travelled this distance and then through the right tube into the uterus, as some suppose to be the usual course, there to be impregnated, and then to return to the fimbriated extremity, there to develop.

The distinctly marked corpus luteum of the left ovary, the occlusion of the left tube, with the ovisac in the extremity of the firmly adherent right tube, unquestionably indicate the route taken by the ovule, *i.e.*, traversing the pelvic cavity.

2. The difficulty of diagnosis amid unusual conditions and deceptive statements is evident, yet laparotomy would have solved all doubts and saved the patient; but though this course seemed to me to be the one indicated, others did not agree with me, as she referred her suffering so distinctly to gastric and intestinal ailments.

The unusual location of the ovisac, of tube and ovary, quite out of reach of the examining finger, and the absence of any accumulation of blood or fluid which could be felt or detected by percussion, together with the tenderness of the abdomen, removed all possibility of determining the actual condition of affairs by vaginal or bimanual examination; the ovarian region was free, and the one point of greater tenderness which did exist was in the region of the appendix. The patient was single, as we may recall, *denied* cessation of menstruation or hemorrhage, and complained of the griping pains of indigestion, from which she was known to have suffered before. Operation was indicated, but whether for inflammation of the appendix vermiformis or some indistinct injury to the uterine appendages, was doubtful.

The difficulties of diagnosis were such that they even persisted during the post-mortem examination, which had been almost concluded upon my arrival without revealing the sources of trouble, as the sexual organs had not been removed, and I was met with the statement, "died from intrapelvic hemorrhage, cause unknown."

But after a more thorough examination and a removal of the organs the curious condition here demonstrated was finally discovered.



3. The clinical history, confirmed by the specimen itself, affords strong evidence in favor of the conservative treatment of pelvic inflammation, and proves that even grave tubo-ovarian disease and violent perimetritis can be *cured*, so far as restoration to health is concerned, *without removal of the appendages*.

The specimen, the indurated, enlarged uterus, the occluded, thickened left tube, the atrophied ovaries, and the adhesions on all sides, in themselves, regardless of the confirmatory history, demonstrate the violence of pelvic inflammation from which the patient suffered when she first entered my clinic years ago, after having been bed-ridden for six months. Again and again I at that time advised removal of the ovaries, and she again and again refused. Treatment was persistently continued for fully two years, but she was restored, led an active life, part of the time as sick-nurse, so that we all know full well of her robust appearance and thorough good health, such as operation, though successful, does not always assure.

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